DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 96-24

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 1996

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447.205

7. FEDERAL BUDGET IMPACT:
a. FFY 1995-1996 $-149.6m
b. FFY 1996-1997 $-299.2m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D Part I Pages 29,29a,32,34,36, 47a,47(a)(1),47(x)(4),47(x)(5),47(x)(7),47(x)(8), 47(x)(9),47(x)(10),47(x)(11),47(s),47(t),51(a), 110(E) Appendix,110(f),110(g),110(h)

**** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D Part I Pages 29,32,34,36, 47(a),47(a)(1),47(x)(4),47(x)(5),47(x)(7), 47(x)(8),47(x)(9),47(x)(10),47(s),47(t), 51(a),110(E) Appendix
No Previous Pages: Attachment 4.19-D Part I 29(a),47(x)(11),110(f),110(g),110(h)

10. SUBJECT OF AMENDMENT:
Long Term Care Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

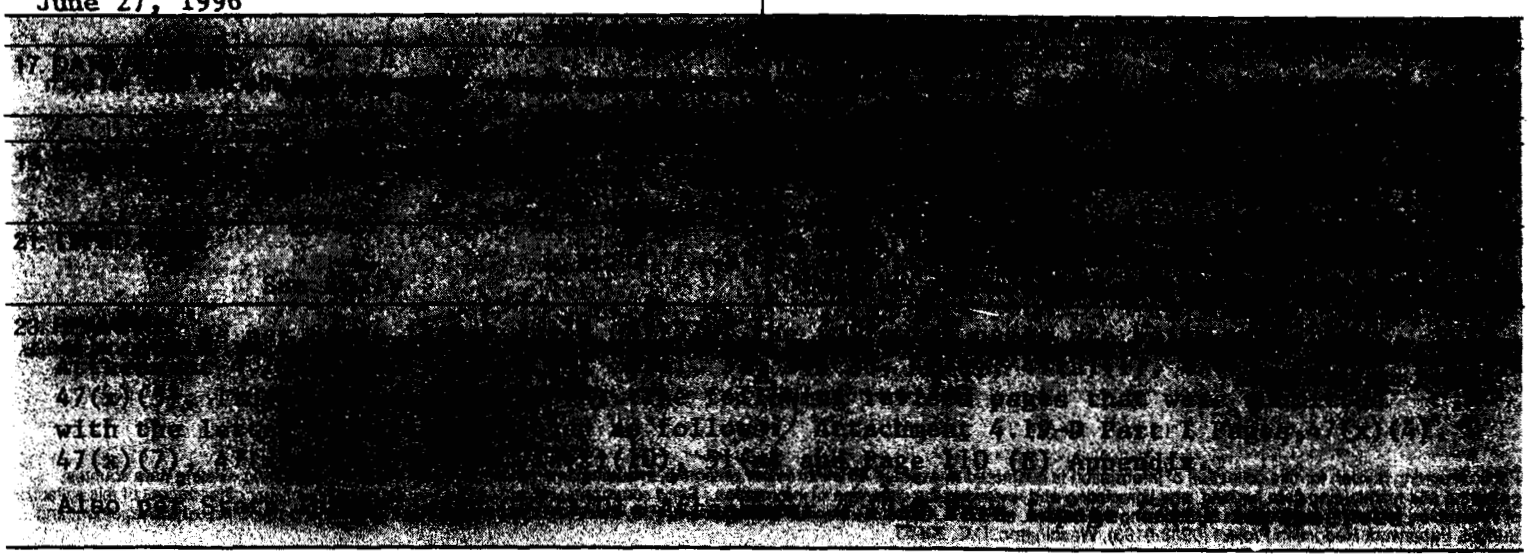
12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Brain J. Wong

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
June 27, 1996

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243



FORM HCFA-179 (07-92)

Instructions on Back

New York

47(t)

Attachment 4.19-D

Part I

(reserved)

TN 96-24 Approval Date JUN 06 2001

Supersedes TN 89-24 Effective Date APR 01 1996

(x) Residential health care facility rates of payment for services provided on or after July 1, 1995 through March 31, 1996 shall be reduced by the Commissioner, to reflect the elimination of operational requirements previously mandated by law or regulation or the Commissioner or other governmental agency, by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each residential health care facility as the result of (a) up to fifty-six million dollars on an annualized basis for 1995, trended to the rate year by the trend factor for projection of reimbursable costs to the rate year, multiplied by (b) the ratio of patient days for patients eligible for payments made by government agencies provided in a base year two years prior to the rate year by a residential health care facility, divided by the total of such patient days summed for all residential health care facilities; and

(ii) the result for each residential health care facility shall be divided by such patient days for patients eligible for payment made by governmental agencies provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.

(iii) Effective April 1, 1996 and thereafter, residential health care facility rates of payment shall be reduced by an annual aggregate amount of fifty-six million dollars to encourage improved productivity and efficiency. Actual reduction in rates within such aggregate amounts will be allocated among facilities based upon each facility's ratio of Medicaid utilization to total statewide Medicaid utilization for all residential health care facilities.

New York
47(x)(7)

Attachment 4.19-D
Part I

Medicare Utilization. (1)(a) Prior to February 1, 1996, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to Medicare beneficiaries, divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing July 1, 1995 to the last date for which such data is available and reasonably accurate. This value shall be called the 1995 statewide target percentage.

(b) Prior to February 1, 1997, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for Medicaid payments expressed as percentage, for the period commencing January 1, 1996 through November 30, 1996 based on such data for such period as is available and reasonably accurate. This value shall be called the 1996 statewide target percentage.

(2) Prior to February 1, 1996 the commissioner of health shall calculate the result of the statewide total of

TN 96-24 Approval Date JUN 06 2001
Supersedes TN 95-24 Effective Date APR 01 1996

Attachment 4.19-D

Part I

health care facility days of care provided to Medicare beneficiaries, divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period April 1, 1994 through March 31, 1995. This value shall be called the statewide base percentage.

(3) (a) If the 1995 statewide target percentage is not at least one percentage point higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1995 statewide target percentage is not atleast one percentage point higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1995 statewide reduction percentage. If the statewide target percentage is at least one percentage point higher than the statewide base percentage, the statewide reduction percentage shall be zero.

(b) If the 1996 statewide target percentage is not at least two percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1996 statewide target percentage is not at least two percentage points higher than the statewide base percentage. The percentage calculated pursuant to this subdivision shall be called the 1996 statewide reduction percentage. If the 1996 statewide target percentage is at

least two percentage points higher than the statewide base percentage, the 1996 statewide reduction percentage shall be zero.

(4) (a) The statewide reduction percentage shall be multiplied by thirty-four million dollars to determine the 1995 statewide aggregate reduction amount. If the statewide reduction percentage shall be zero, there shall be no reduction amount.

(b) The 1996 statewide reduction percentage as calculated in paragraph 3(b) of this section shall be multiplied by sixty-eight million dollars to determine the 1996 statewide aggregate reduction amount. If the statewide reduction percentage shall be zero, there shall be no reduction amount.

(5) (a) The 1995 statewide aggregate reduction amount shall be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage. This amount shall be called the 1995 facility specific reduction amount.

(b) The 1996 statewide aggregate reduction amount shall be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for Medicaid payments on the basis of the extent of each facility's failure to achieve a two percentage point increase in the 1996 target percentage compared to the base percentage calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage point increase in the 1996 target percentage compared to the base percentage. This amount shall be called the 1996 facility specific reduction amount.

(6) The facility specific reduction amount shall be due to the state from each residential health care facility and may be recouped by the state in a lump sum amount from Medicaid payments due to the residential health care facility.

(7) Residential health care facilities shall submit such utilization data and information as the commissioner of health may require for purposes of this section. The commissioner of health may use utilization data available from third party payers in the event such data become known.

(8) On or about June 1, 1996, the commissioner of

health shall calculate for the period July 1, 1995 through March 31, 1996 a statewide target percentage, a statewide reduction percentage, a statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraph 1(a), 3(a), 4(a) and 5(a) of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the 1995 facility specific reduction amount calculated in accordance with paragraph 5(a) of this provision. Any amount in excess of the amount determined in accordance with paragrph 5(a) of this provision shall be due to the state from each residential health care facility and may be recouped in the same manner as specified in paragrph 6 of this provision. If the amount is less than the amount determined in accordance with paragraph 5(a) of this provision, the difference shall be refunded to the residential health care facility by the state no later than July 15, 1996. Residentil health care facilities shall submit utilization data for the period July 1, 1995 through March 31, 1996 to the commissioner of health by April 15, 1996.

(f)(1) On or about September first of each year, the consultants shall provide to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factors for the rate period, commencing on the next January first. The Commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the initial trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factors were established and one prospective final annual adjustment to the revised trend factors to reflect such price movements and to be effective on January first, two years after the initial trend factors were established.

(2) Notwithstanding the dates specified in paragraph (1), the consultants shall provide as soon as possible to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factor for the rate period April 1, 1991 to December 31, 1991. One prospective interim annual adjustment for this rate period shall be made on January 1, 1992 and one prospective final annual adjustment for this rate period shall be made January 1, 1993.

(g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d),(e) and (f) of this section shall reflect no trend factor projections applicable to the period January 1, 1995 through December 31, 1995 and no trend factor adjustments applicable to periods prior to January 1, 1995 other than those reflected in 1994 rates of payment and provided further, that this subdivision shall not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health shall adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments, but shall include the full or partial value of the retroactive impact of trend factor final adjustments for prior periods.*

*This means that since the rates for the April 1, 1996 through March 31, 1997 period are based on 1983 base year costs trended to this period, the rate impacts of any differences between the final or interim value of prior trend factors to the corresponding preliminary or interim trend factor values that were used when initially calculating the rates of payment shall only reflect adjustments for the periods the trend factors were paid.

New York
110(E)
Appendix

Attachment 4.19D
Part I

Provider Assessments. For purposes of determining rates of payment for residential health care facilities beginning July 1, 1992 for beneficiaries eligible for medical assistance under Title XIX of the federal Social Security Act, a state assessment of 1.2% of residential health care facility gross revenues received during the period April 1, 1992 through March 31, 1994, and as may be extended by statute, shall be a reimburseable cost to be included in calculating rates of payment. The state assessment of 1.2% of RHCF gross revenues shall be in effect from April 1, 1992 through March 31, 1994, and as may be extended by statute. Effective July 1, 1995 through March 31, 1996, and as may be extended by statute, an additional state assessment of 3.8% of facility gross revenues shall be a reimbursable cost to be included in calculating rates of payment.

Effective for the period April 1, 1996 through April 30, 1996, the further additional assessment will be reduced from 3.8% to 1.9% of each facility's cash receipts from all patient care services and other operating income, for a total state assessment of 3.1% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment. Effective on or after May 1, 1996, rates of payment will be adjusted to allow costs associated with a total state assessment of 5.4% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates based on a reconciliation of actual assessment payments to estimated payments.[1]

---

[1] The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

TN 96-24 Approval Date JUN 06 2001
Supersedes TN 95-24B Effective Date APR 01 1996